July 12, 2026

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The Honorable Russell T. Vought
Director, U.S. Office of Management and Budget
The White House

RE: Regulation for Federal Financial Assistance (OMB-2026-0034)

Dear Director Vought,

Thank you for the opportunity to comment on the Office of Management and Budget (OMB)'s proposed revisions to 2 CFR Part 200 governing Federal Financial Assistance (herein referred to as the "Uniform Guidance"). We are writing to express strong opposition to the proposed rule and significant concern about its implications for federal award applicants, recipients, and the communities they serve.

Alzheimer's disease and related disorders (AD/ADRD) represent one of the most significant public health challenges facing the United States today and in the decades ahead. Progress toward the goals of the National Plan to Address Alzheimer's Disease, as mandated through PL 118-92, depends on stable federal grant investments to support dementia-capable community systems, workforce development, public health implementation, and scientific research. Our comments focus on the implications of the proposed revisions to the Uniform Guidance on vital federal programs addressing AD/ADRD, including (but not limited to) grant programs funded and administered by the Administration for Community Living (ACL), the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Department of Defense (DoD), and the Department of Justice (DoJ).

National AD/ADRD infrastructure depends on the flexibilities and protections provided by the current Uniform Guidance in 2 CFR Part 200. Numerous proposed revisions would adversely affect individuals living with AD/ADRD, their care partners and families, as well as the community-based organizations, aging services networks, and state and local partners that support them. These concerns are particularly significant because federal AD/ADRD

investments are not intended to simply deliver discrete services with immediate, measurable outputs; instead, these investments are designed to build systems that create enduring public value that extends well beyond a period of federal funding. Weakening the stability afforded by the current framework risks undermining existing investments before their full benefits can be realized and jeopardizing essential systems that support individuals living with AD/ADRD and those who care for them.

In this submission, we outline an illustrative – ***not*** exhaustive – set of objections to the proposed revisions. In brief, the proposed rule and all its component parts are fundamentally flawed, as it would:

1. Increase administrative burden on applicants and grantees, despite OMB's stated goal of reducing such burden.
2. Replace expert judgment with political appointee decision-making, creating a chilling effect on productive and strategic grant administration.
3. Rely on undefined or inconsistently defined terms that impede implementation and diminish the return on investment for the American people.

As a consequence, and on behalf of all Americans who are at risk or currently living with AD/ADRD, **we strongly urge OMB to withdraw this proposed rule in its entirety**.

We cite the following as exemplar provisions we strongly oppose:

[200.202]

- § 200.202(a): While improved program planning could strengthen federal investments, this provision outlines an increased emphasis on predefined outcomes and agency priorities, which inevitably will limit flexibility for emerging areas of need and opportunity. AD/ADRD initiatives often require adaptive approaches because community needs, caregiving challenges, service delivery models, and scientific opportunities are continuously evolving. Overly prescriptive program design would constrain innovation and reduce the ability of community-based organizations and partners to develop tailored solutions for their community.

- § 200.202(b): The proposed removal of this provision would eliminate important guidance encouraging federal agencies to consult with communities impacted by federal programs, consider available evidence and evaluation results, and ensure broad access to funding opportunities. For AD/ADRD initiatives, meaningful engagement with individuals living with mild cognitive impairment or dementia, care partners, and community-based organizations is essential to designing effective programs that reflect real-world needs. The proposed rule risks investing taxpayer money in programs and innovations that end-users do not value.

- § 200.202(d): This provision would restrict grant eligibility and give the administration more oversight into the specific institutions and organizations that receive federal funding. Numerous small, community-based organizations receiving ACL, HRSA, and CDC funding bring unique expertise in the development of AD/ADRD infrastructure to

best meet local needs (rather than a top-down, one-size-fits-all approach). OMB must reevaluate the practical impact of this provision; although intended to promote competition and transparency in federal award programs, it will ultimately disadvantage and restrict eligibility among small, nonprofit organizations to the detriment of people living with AD/ADRD.

[200.205]

- §200.205(c): This provision calls for the introduction of unwarranted and counter-productive political bias in the decision-making process. For AD/ADRD research, public health programs, and community-based initiatives, independent review by qualified experts is absolutely essential to ensuring funding decisions are informed by evidence, lived experience, and field expertise, and serve the community's needs. Regardless of party affiliation and political ideology, a political appointee's opinion or agenda should **not** be prioritized over subject matter expertise, technical review panels, and established evaluation practices. There should be no political litmus test or appearance of a political litmus test about which communities, organizations, or segments of the American population should be favored or disfavored in federal funding to address AD/ADRD.

[200.206]

- § 200.206(b)(2): The expanded risk assessment criteria outlined in this provision introduce additional discretion into award decisions without clearly defining how these factors will be weighted. Community-based organizations, care partner support programs, and local aging services providers often operate with limited administrative capacity but deliver essential and highly effective services. These risk assessments will inadvertently favor large cities and institutions with greater resources at the expense of small towns and local community organizations with deep community expertise and demonstrated programmatic impact. Particularly given the higher incidence of AD/ADRD among rural Americans, this provision would have the unintended consequence of exacerbating structural health care and social service access disparities faced by rural Americans living with AD/ADRD.

[200.300]

- §200.300(b)(c): AD/ADRD disproportionately affects certain populations, including people with Down syndrome, people with certain immutable biological or genetic characteristics (e.g., women, indigenous people, African Americans, Hispanic/Latinx Americans), and people living in rural communities and other underserved areas. These provisions would introduce new limitations on authorized use of federal funds associated with carrying out critical activities to address documented health disparities. Grant recipients must retain the flexibility to carry out evidence-based efforts to address health disparities – including tailored outreach to individuals for culturally-competent public health, clinical care, social services, and clinical trials – and should not be restricted by broad prohibitions or undefined terms. By ignoring differences in how AD/ADRD affect

various populations, this provision would have the unintended consequence of weakening the efficacy of taxpayer investments and willfully restricting the benefits of AD/ADRD advancements to only a subset of the full AD/ADRD population.

[200.340]

- § 200.340(a) – This provision aims to expand federal discretion to terminate or discontinue awards and increase administrative requirements. Ultimately, the provision creates funding instability that undermines progress that has taken years to achieve and will cause a chilling effect on potential applicants. Additional administrative burden is certain to have a disproportionate effect on small, community-based networks serving the AD/ADRD community and on AD/ADRD scientists at less wealthy or influential academic institutions.

National AD/ADRD infrastructure depends on the flexibilities and protections provided by the current Uniform Guidance in 2 CFR Part 200. The above example proposed revisions, along with numerous other provisions, would adversely affect individuals living with AD/ADRD, their care partners and families, as well as the community-based organizations, aging services networks, researchers, and state and local partners that support them. Further details on exemplar agency-specific AD/ADRD efforts that would be impacted by these proposed revisions are outlined below.

Administration for Community Living (ACL)

ACL serves as the primary federal agency supporting dementia-capable home and community-based services (HCBS), care navigation, support for care partners, and community-based care infrastructure for individuals living with AD/ADRD. ACL, through the Alzheimer's Disease Programs Initiative (ADPI) supports dementia-capable systems grants, caregiver support initiatives, and related efforts to help communities across the country develop coordinated systems that enable individuals living with AD/ADRD to remain safely and successfully in their homes and communities.

These investments are especially important in rural, Tribal, and other underserved communities, where formal services are often limited and family care partners frequently serve as the primary source of support. ACL-funded programs help bridge these gaps by supporting locally-tailored and culturally competent services, care partner education, care coordination, respite, and community-based interventions that improve quality of life for both individuals living with AD/ADRD and their care partners.

The proposed revisions to the Uniform Guidance fail to adequately account for the realities faced by many ACL awardees. Unlike large academic institutions or health systems, ACL-funded organizations are often small nonprofits, community-based organizations, Tribal entities, local service providers, and small local governments operating with limited administrative infrastructure. Although many of these organizations operate with limited administrative capacity, **they have earned community trust and possess cultural**

competence and local expertise necessary to identify and reach individuals living with AD/ADRD—particularly those who may otherwise remain disconnected from other health and social service systems. Implementing eligibility restrictions that effectively exclude these organizations from applying is unreasonable and unacceptable.

Furthermore, these grants are designed to catalyze lasting change—not create permanent dependence on federal funding. A 2026 report found that the vast majority of ACL-funded AD/ADRD programs continue long after federal grant funding ends by securing diverse funding sources, integrating services into existing systems of care, and building strong community partnerships. Preserving these early ACL investments ensures that proven programs can reach long-term sustainability, rather than being cut short before communities realize their full benefit.

Health Resources and Services Administration (HRSA)

HRSA-funded programs are foundational to the nation's efforts to build and sustain a dementia-capable workforce and to strengthen health care systems serving individuals living with and at risk for AD/ADRD. Through investments in programs such as the Geriatrics Workforce Enhancement Program (GWEP), rural health initiatives, primary care training programs, geriatric education efforts, and workforce development partnerships, HRSA has helped expand the capacity of clinicians and health systems in many of America's most medically underserved local communities to diagnose, treat, and support individuals and families affected by AD/ADRD.

Similar to ACL-funded grants, HRSA investments are particularly critical in rural, Tribal, and other medically underserved communities, where systemic workforce shortages and limited access to specialty care create significant barriers to timely diagnosis and ongoing care and support. HRSA-funded programs have enabled the development of innovative training models, interdisciplinary care teams, telehealth-based consultation networks, and community partnerships that bring AD/ADRD expertise to areas that would otherwise have little or no access to these essential services.

Training clinicians, integrating AD/ADRD care into primary care settings, expanding geriatric expertise across health systems, and establishing sustainable local referral and support networks all require years of coordinated investment, locally-tailored implementation, and adaptation based on experience over time and evolving community needs. Partnerships – between health systems, community health centers, academic institutions, non-profit organizations, local government, and other partners – require stability and predictability to earn local trust, recruit and train clinicians, develop curricula, establish care pathways, and embed AD/ADRD expertise into routine practice. The value of these efforts grows over time as trained providers remain in their communities, mentor future clinicians, and strengthen local capacity to meet the needs of an aging population. Building such a dementia-capable local workforce is not an outcome that can be achieved or fully measured within a single budget or electoral cycle, yet the proposed revisions to the Uniform Guidance introduce an untenable and counterproductive degree of risk, administrative burden, and uncertainty to workforce development and systems

transformation based on short-term political objectives or turnover in political appointees. Chaos and the risk of chaos – driven by shifting political climate – are antithetical to building effective local partnerships that benefit people living with AD/ADRD.

The nation's AD/ADRD workforce cannot be built through unreliable, short-term, transactional grants, and certainly are not enhanced by the increased administrative burden put on grantees whose top priority is to serve their communities. Yet the proposed revisions to the Uniform Guidance would make it more difficult for organizations to sustain and expand the workforce, ultimately exacerbating existing challenges for people with AD/ADRD. Protecting and strengthening HRSA's ability to support these community-based collaborative efforts is essential to ensuring that individuals living with AD/ADRD have access to sustainable, high-quality, culturally competent, and evidence-based care.

Centers for Disease Control and Prevention (CDC)

The CDC plays a critical role in advancing a public health approach to AD/ADRD, supporting efforts to promote risk reduction, improve early detection and diagnosis, strengthen care partner health, and build public health capacity nationwide. Through implementation of the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act (P.L. 118-142) and related initiatives, CDC investments have helped establish the foundation for state and local public health systems to address the growing impact of AD/ADRD on individuals, families, care partners, and local communities.

CDC-funded AD/ADRD programs operate through partnerships with state and local health departments, universities, Tribal organizations, public health agencies, health systems, and community-based organizations and businesses. These collaborative efforts have expanded public awareness and contributed to healthier lifestyle choices, integrated AD/ADRD efforts into public health planning, and improved population data collection.

The success of public health approaches to AD/ADRD relies on sustained engagement, community trust, and fidelity to long-term implementation strategies. Public health initiatives often produce substantial measurable impact gradually over time – increased awareness, reduced stigma, adoption of risk-reduction strategies, earlier diagnosis, improved care partner support and health, and stronger public health systems are outcomes that develop incrementally and require predictable, consistent investment over multiple years.

Proposed Uniform Guidance provisions will undermine long-term public health planning and implementation efforts that are vital to achieving national AD/ADRD goals. CDC-funded grant recipients are developing and implementing multi-year strategies, establishing community-wide and statewide partnerships, building public health surveillance systems, delivering evidence-based interventions, and engaging communities in sustained outreach efforts. These activities require stable funding environments and predictable grant administration to ensure continuity of adherence to evidence-based best practices and to maximize public health impact. Successful AD/ADRD public health initiatives require collaboration among community-based

organizations to reach various segments of the population. Faith communities, volunteer groups, health care systems, schools, local businesses, disease-specific non-profits, and others provide a trusted voice to reach their distinct audiences, reinforce each other's information with common or overlapping audiences, and contribute expertise to specific and interconnected elements of AD/ADRD public health education. Unfortunately, the proposed rule likely would weaken such collaborations. The proposed rule would create a chilling effect with vital community-based organizations less willing to enter into partnerships with grantees due to the instability and unreliability of the funding, actual or feared political litmus tests of key partners, and the administrative burdens. In parallel, the administrative burdens on grantees to monitor even the non-grant related activities of community-based partner organizations likely would have a chilling effect on the scope of collaborations sought and therefore on grant program efficacy. Particularly for people living with AD/ADRD, who typically have numerous co-occurring health conditions and social service needs, the proposed rule threatens to subvert effective and essential public health collaborations by making it functionally impossible to engage the full range of community-based partners.

The final rule must preserve the flexibility necessary for CDC-funded recipients to conduct sustained and predictable community outreach, stakeholder engagement, public education, and other evidence-based public health activities that are central to addressing AD/ADRD at the population level. Protecting these investments is particularly important in rural, Tribal, and underserved communities, where public health infrastructure often serves as the primary mechanism for promoting brain health and responding to the growing challenge of AD/ADRD.

National Institutes of Health

The NIH is the primary funder of biomedical research in the world and has been instrumental in driving AD/ADRD scientific advances that are transforming the field and improving the lives of millions of people across the United States. Sustained federal investment over the last decade has accelerated discovery across the research continuum, from basic science and biomarker development to clinical trials and the development of new diagnostics and therapies both to treat AD/ADRD symptoms and slow disease progression. These investments have created a robust national research infrastructure that is generating unprecedented progress in understanding disease mechanisms, improving early detection and diagnosis, and identifying interventions that can reduce risk (or prevent), delay, and treat AD/ADRD.

NIH-funded AD/ADRD research involves longitudinal cohort studies, clinical trials, biomarker validation efforts, translational science initiatives, and large-scale collaborative research networks that span many years, and require enormous commitment from researchers as well as the volunteer study participant community. **This research is particularly vulnerable to disruptions.** Recruiting participants for AD/ADRD clinical trials is already challenging, requiring years of community engagement, trust-building, and collaboration with patients, families, care partners, clinicians, and local organizations. Greater uncertainty surrounding the continuation of awards or increased perceptions that research projects may be subject to shifting politicized priorities will further discourage participation in clinical trials. Put bluntly, the proposed Uniform

Guidance provisions jeopardize all AD/ADRD research by creating an environment in which prospective research participants may be dissuaded from volunteering for fear of politics outweighing scientific merit in the awarding of grants and current research participants would be subjected to unnecessary and harmful distress about their medical care being interrupted and years of volunteer effort being wasted due to political considerations. **Any reduction in recruitment or retention would slow the pace of scientific discovery and delay the development of urgently-needed diagnostics and treatments.**

Disruptions to ongoing studies also have consequences that extend well beyond financial costs. Prematurely interrupting or terminating research may result in the loss of valuable scientific data and waste significant public investments in grant funding and institutional infrastructure. Of utmost importance, such disruptions may also adversely affect study participants and their care partners, who often rely on research participation not only for access to investigational therapies or non-pharmacological interventions, but also for specialized clinical monitoring, care coordination, cognitive assessments, and other health and support services provided through the study. The proposed rule creates particular danger to the health and safety of patients who may face sudden and unplanned disruption or discontinuation of medical interventions where their medical team has no time and resources, and therefore no ability, to manage a medically prudent transition (e.g., tapering off of a medicine, transitioning to a new provider). In the case of AD/ADRD research, a number of current drug treatments in clinical trials have potentially serious side effects such as Amyloid-Related Imaging Abnormalities (ARIA) that require careful, consistent, and complex safety monitoring. Abruptly suspending or terminating grant funding for such a trial literally risks serious avoidable harm and potential death for study participants. **Preserving continuity in long-term clinical research is important both for scientific integrity and for the well-being of participants.**

Excessive administrative burden will also divert investigator time and institutional resources away from research activities. Smaller research institutions, emerging investigators, and community-based research partners may be particularly affected by increased compliance requirements, potentially limiting participation in federally funded research and reducing the diversity of research settings and study populations (particularly in more rural and medically underserved communities). Larger institutions, who may subcontract aspects of their work, may also be less apt to apply for support given these excessive administrative burdens.

Scientific breakthroughs in AD/ADRD are the result of decades of sustained investment, collaboration, and infrastructure development – and commitments from study participants and care partners. The research ecosystem that supports discovery and breakthroughs cannot be sustained through short-term or uncertain, or politically vacillating funding mechanisms. The proposed revisions to the Uniform Guidance fail to recognize the unique requirements of long-term biomedical research and preserve the stability and flexibility necessary to continue advancing scientific progress, accelerating innovation, and delivering new treatments and care approaches to individuals living with AD/ADRD and their families.

Furthermore, by substituting political ideology in place of subject matter expertise, technical review panels, and established evaluation practices, the proposed rule abandons what NIH has

outlined as “Gold Standard Science” via the *“Leading in Gold Standard Science: An NIH Implementation Plan*,” released in August 2025 under the Trump Administration. More specifically, the 2025 NIH implementation plan notes the agency’s efforts *“to ensure that it funds the highest quality research free from influence or bias.*” The plan goes on to state:

> *“By prioritizing unbiased peer review of research proposals and manuscripts that report the results of federally-funded research, NIH can continue to protect the public’s investment in biomedical research from bias and build public trust. Approximately 80 percent of NIH’s budget in biomedical research supports extramural researchers at institutions in every state in the country. Given the size and breadth of this investment, NIH has a robust infrastructure to ensure unbiased peer review and procedures to address allegations of biased peer review. The core values of NIH peer review are expert assessment, transparency, impartiality, fairness, confidentiality, security, integrity, and efficiency.”*

Surely, the movement by OMB to inject bias into the NIH peer review process undermines the 2025 NIH implementation plan and essentially redefines – in an antithetical fashion – what this Administration characterizes as “Gold Standard Science.” This is precisely the sort of intentional infliction of chaos that subverts the credibility of science and government and dismantles the stable, predictable research infrastructure that “rigorous” science requires – and upon which the American public relies for biomedical advances.

As the proposed rules weakens the NIH’s peer-review grant making processes, it also weakens public-private partnerships with AD/ADRD research foundations and the biomedical/biotech industries. Both foundations and industry need to know that NIH is making decisions based on scientific rigor and merit, and that NIH’s funding commitments are stable and reliable across Administrations. The proposed rule would compromise private sector confidence in collaborating with NIH and thereby threaten private sector investment, slow scientific innovation, and jeopardize progress for the American people in addressing AD/ADRD.

Imposing new and unreasonable restraints on scientific discovery would encourage low-risk/low-reward proposals, stifling the very American exceptionalism that has made the United States the unrivaled global leader in science and driven much of America’s economic prosperity since the mid-20th century. If the American people are to be first to benefit from new AD/ADRD diagnostics, treatments, and eventual cures, those discoveries need to happen here at home and not in fast rising scientific leadership competitors such as China. An unintended consequence of the proposed rule would be to hurt Americans living with AD/ADRD while strengthening China at America’s expense.

Department of Defense

Since 2012, the DoD’s Congressionally Directed Medical Research Programs (CDMRP) have included the Peer Reviewed Alzheimer's Research Program (AZRP). The program addresses the long-term consequences of traumatic brain injury (TBI) as they pertain to AD/ADRD,

including understanding the association between TBI and these diseases, and reducing the burden on affected individuals and caregivers, especially in the military and veteran communities. Over the past dozen years, CDMRP has invested more than $225 million in impactful, solution-oriented research to address critical needs and improve quality of life for service members, veterans, their families, and the public who are living with AD/ADRD – critical research as people are at a 70% greater risk of dementia after a TBI and veterans are two to eight times more likely than the general population to develop dementia after a TBI.

Because AZRP provides relatively small grants and requires all clinical research awards to include community collaboration, there is a particularly high risk that the administrative burden created by the proposed revisions will create a chilling effect, dissuading even highly meritorious proposals from being submitted for consideration. Even proposals that are submitted likely will have fewer and potentially weaker community partnerships as such community-based organizations would recognize the inherent instability of funding due to the proposed rule's amplification of risk for grant suspensions and terminations by non-expert political appointees able to rely on vague and undefined terms such as "*...including when the award no longer advances [Federal] agency priorities or the national interest…*"

Similarly, subordinating the role of peer review in the grant making process – especially when coupled with the proposed rule's reliance on undefined terms such as "Gold Standard Science" – in favor of non-expert political appointees will diminish the range of community partnerships available to researchers. In turn, this would threaten to limit the efficacy of the research itself. The result would be less value for taxpayers and less benefit for service members, veterans, and their families.

Department of Justice

Kevin and Avonte's Law (PL-115-141) authorizes the DOJ Bureau of Justice Assistance (BJA) supports local efforts to improve the safety of individuals with AD/ADRD or developmental disabilities, such as autism, who – due to their condition – are at risk for wandering. BJA's Kevin and Avonte Program provides funding to health care, law enforcement, and other public safety agencies to implement locative technologies that track missing individuals. The program also provides funding to such agencies and partnering non-profit organizations to develop and operative programs to prevent wander, increase safety, and facilitate rescues.

Up to 60% of individuals with dementia will wander at least once. If they are not found within 24 hours, up to 50% face serious injury or death. The most common causes of death during these incidents are exposure to extreme weather, drowning, and accidents. These BJA grants are essential to helping local communities deploy locative technology, train first responders, and strengthen partnerships among law enforcement, care partners, and community organizations to protect the health and safety of people at risk of wandering. Abruptly terminating a grant immediately affects continuity of these services, and can disrupt locative technology deployment and community outreach to care for individuals in distress. Increasing administrative burden on applicants and awardees diverts staff focus, reducing the time and resources that can be spent

locating missing individuals. More stringent pre-award review requirements could also make it more difficult for these organizations to compete for funding, potentially reducing access to these services in rural and other underserved communities. The proposed rule would substitute the preferences of non-expert political appointees for the expert judgment of BJA grant reviewers thereby threatening the ability of local public safety agencies and their local partnering organizations to protect the lives of people with AD/ADRD who wander.

The Aggregate Impact

These proposed revisions to the Uniform Guidance are **not** isolated technical changes. Rather, these are government-wide changes across 42 federal agencies, with significant, cumulative harmful impact on federally-funded activities and devastating down-stream effects on millions of Americans facing AD/ADRD. OMB must reevaluate how the proposed changes would affect the federal government's ability to achieve the goals of the National Plan to Address Alzheimer's Disease, including accelerating research, reducing risk for AD/ADRD, improving clinical care and quality of life for individuals living with AD/ADRD, expanding support for care partners, enhancing public health capacity, and strengthening long-term services and supports.

In addition to making substantial changes to the Uniform Guidance, the proposed rule would fundamentally restructure the federal grants framework by converting long-standing guidance into binding regulation, centralizing future revisions through OMB rulemaking, and reshaping the administration of federal financial assistance across dozens of agencies. Collectively, these changes would introduce significant new administrative requirements and burdens, reduce flexibility, and create uncertainty for recipients that depend on merit-based and stable federal partnerships to carry out long-term, mission-critical work for the American people. More than 140 years after the Pendleton Civil Service Act of 1883, the OMB proposed rule threatens to reintroduce the most corrosive and corrupting aspects of the Spoils System, undermining public confidence that public services are merit and evidence-based rather than riven with political influence.

For the AD/ADRD community, these changes would reverberate across the entire continuum of community-based services, workforce development, clinical care, public health, and research. ACL-funded programs rely on trusted community organizations to provide caregiver support, care navigation, respite, and dementia-capable home and community-based services. HRSA investments support the development of a dementia-capable workforce, particularly in rural and underserved communities. CDC programs require sustained partnerships to build public health capacity and implement the BOLD Infrastructure for Alzheimer's Act. NIH-funded research depends on merit-based decision-making, long-term scientific infrastructure, and multi-year studies to advance human health. DoD-funded research requires peer-reviewed science and strong community partnerships to advance health for veterans and their families. DOJ BJA supports critical partnerships amongst law enforcement and local organizations to protect the safety of vulnerable individuals. Each of these investments is interconnected, and weakening any one component risks slowing progress across the broader national response to AD/ADRD.

OMB must evaluate the potential unintended consequences for the federal programs that have driven unprecedented progress against AD/ADRD over the past decade for the American people. Efforts to strengthen political accountability should not come at the expense of research innovation, caregiver support, public health infrastructure, workforce development, or community-based systems of care. Any update to the Uniform Guidance must preserve the rigor, flexibility, stability, and long-term partnerships that are essential to sustaining progress toward the goals of the National Plan and improving outcomes for people living with AD/ADRD and their families.

Conclusion

Thank you for the opportunity to provide comments. Although we agree that efficiency, oversight, and accountability are important, they should not come at the cost of dismantling the infrastructure that federal investments have built to serve communities across the United States.

Through this proposed rule, OMB is taking severe, counterproductive steps to create a system that undermines research, supports and services, public health initiatives, and community partnerships on which millions of Americans depend. Rather than improving the stewardship of federal resources, the proposal weakens the ability of organizations to deliver evidence-based, essential programs and services to people living with AD/ADRD and the family members and friends who care for them **On behalf of all Americans who are at risk or currently living with AD/ADRD, we strongly urge OMB to withdraw this proposed rule in its entirety.**

For any questions or additional information, please contact Ian Kremer, executive director of LEAD Coalition, ikremer@leadcoalition.org, or Courtney Wallin, federal policy director of the LEAD Coalition, cwallin@leadcoalition.org.

Sincerely,

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